Written Testimony on Implementation of the Sandra Bland Act
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Good morning, Chairman Coleman and Committee members. I'm Michele Deitch and I teach at the LBJ School of Public Affairs at the University of Texas. It's good to be back before this Committee again—albeit long distance—and, Chairman Coleman, I appreciate your invitation to testify.

Let me start by saying how grateful I am to you, Chairman, for your leadership on the Sandra Bland Act, and really to all of you for your strong support for this very important bill. The bill—and the hearings leading up to its passage—did a great job of raising public awareness of a number of critical issues affecting the well-being of citizens both in their interactions with the police and while they are incarcerated in jails pretrial.

If implemented properly, the bill will go a long way towards improving the care and treatment of people with mental illness in Texas jails, and towards improving jail safety for all inmates.

In the few minutes I have before you today, I want to highlight certain provisions in the bill that deal specifically with jail safety and jail standards, and my hopes for implementation regarding these provisions. I will leave other sections of the bill—especially the diversion, mental health, and de-escalation provisions—to some of the other experts who will come before you today.

(1) Serious Incidents Report

You will recall that the Act requires every jail to produce a monthly report to the Jail Commission of serious incidents in the jail. Serious incidents include events such as suicides, attempted suicides, deaths, serious bodily injuries, assaults, escapes, sexual assaults, and use of force that results in bodily injury. That list is not exclusive, however, and the Commission could identify other types of serious incidents that should also warrant a monthly report.

The objectives of this provision are to:

(1) provide greater transparency about what is happening in the jails around the state, since we (meaning both citizens and lawmakers) typically don't learn of a problem unless or until the media gets hold of a particular story;

(2) provide an early warning sign to the Commission, which can look for patterns or disturbing trends in the data and can use this information to help them decide what issues to focus on during their inspections; and

(3) allow for easier analysis of the information that can ultimately help lawmakers to address areas of concern.

In order to help make this provision as useful as it is intended to be, I would encourage the Jail Commission to take several steps during the implementation process. In addition to prescribing a form for the jails to report this information, the Commission staff need to develop a plan for compiling the information in a manner that allows for meaningful analysis.

Specifically, I would encourage the Commission to:

--develop a database that allows for these incidents to be tracked over time by facility (for example, if uses of force with bodily injury start rising steeply at a facility, that would be worth looking into);

--ensure the database allows for comparisons among similarly-sized facilities (for example, if one facility has an unusually high rate of attempted suicides or assaults, that should raise red flags);

--post the data on its website to enable easy access for researchers and the media; and

--include an analysis of the information in a bi-annual report to the Legislature

(2) Independent Investigation of Deaths in County Jail

One provision in the Sandra Bland Act that has gotten a great deal of media attention is the requirement that deaths in jail custody be investigated by an independent law enforcement agency. Of course, this makes sense from the standpoint of improving public confidence in these investigations.

The Jail Commission is charged with developing rules relating to the appointment of such independent law enforcement agencies. My hope is that DPS will be the agency appointed to investigate these cases as a routine measure. An investigation by DPS would carry credibility with the public, and having a single source for these investigations would allow for DPS to develop a special level of expertise in this area.

(3) Electronic sensors for cell checks

A recurring problem in many jails—a problem that was brought to light in the case of Sandra Bland—is the failure of some officers to conduct their routine cell checks in a timely fashion.

These cell checks are critical from the standpoint of jail safety. They allow an officer to discover quickly whether an inmate is in danger, whether it be danger from an attempted suicide, from a physical ailment, or from another inmate. Depending on the level of risk presented by an inmate's situation, these checks may be mandated to occur anywhere from once every 30 minutes to every 15 minutes or even "constant supervision," which means every 5 minutes.

In my experience working with jails and prisons, it is all too frequent an occurrence for some officers to either skip these checks entirely for a period of time, to conduct them in a delayed fashion, or to falsify the records to show that they conducted them.

The reasons for this range from understaffing in a facility that results in overworked officers, to a lack of training, to laziness.

There is no question that the lack of timely cell-checks can lead to deaths or serious injuries. Even a five-minute delay in discovering that someone has attempted to hang himself or had a heart attack can turn a critical situation into a deadly one.

Thus, the provision in the Act that encourages jails to install electronic sensors or cameras to aid in ensuring accurate and timely in-person cell checks is well-intentioned and potentially helpful.

But I do want to sound a note of caution, too. Even the best electronic sensor system won't solve the problem of understaffed jails or a lack of training. If officers don't have enough time to do the checks, then these checks won't happen even if the electronic sensors are in place.

What's more, the electronic sensors don't tell supervisors whether the officers are actually ENGAGING with the inmates during their rounds. It's not enough for an officer to simply glance in the cell. Best practices require them to engage with the inmates, whether to answer inmates' questions, to check on their mental health, to find out what they need, or simply to help establish better relationships. One of the best ways to reduce tensions in the jail and to protect inmate safety is for inmates and staff to TALK to each other.

We should never mistake touching a wand to an electronic sensor as a meaningful interaction between officer and inmate. Training staff about the importance of having effective relationships with inmates is the best way to ensure that this happens.

(4) Continuity of Prescription Medication

Finally, I will briefly mention the critical importance of the provision in the Act requiring the Jail Commission to develop standards regarding the continuity of prescription medications. I know that you have other witnesses who will also speak to this issue.

I have encountered numerous cases over the years of individuals who have died or been seriously injured by their lack of access to prescription medications after they have been booked in the jail.

Bear in mind that when a person is arrested, that moment becomes a sharp break with everything they had access to in the "free world," for better or worse. That means that if the person is on heart medication, or uses an asthma inhaler, or takes psychotropic drugs, he can't access those medications. Some jails have *ad hoc* rules that allow family members to bring medications to the jail once prescriptions are verified with a pharmacy. But there is a great deal of inconsistency on this front, and delays in receiving the appropriate medication could be the difference between life and death.

Moreover, some jails require a person to use whatever medication is prescribed by the jail's doctor—often the cheapest medication available, rather than the most effective—even if it is a different medication than what that person uses on the outside. Of course, this can lead to unexpected side effects, and can throw off whatever gains were achieved by the outside medication regime. For example, an HIV "cocktail" of drugs relies for its effectiveness on consistency in use.

Thus, I hope that the standards developed by the Jail Commission allow for: (1) jail staff coordination with outside health care providers to ensure continuity of the same prescription medications; (2) timely access to those medications; and (3) family members to bring verified prescriptions to the jail to aid in inmate access to the medications in a timely manner.

I will stop there, but I am happy to answer any questions you have. Again, I appreciate your commitment to jail safety and to effective implementation of this bill.